Early Identification and Intervention

Betty Walton
Transformation Work Group Subcommittee
March 9, 2006

Objectives

- **Screening, Assessing and Treating the Mental Health Issues of Children within the Child Welfare System**

- **Child and Adolescent Needs and Strength (CANS)**

Policy Academy – 2004
(Cross System Team, CST)

Application to Georgetown University Policy Academy

Earlier cross system work regarding local systems of care and development of the 1915c Medicaid Waiver for Children with SED

Competitive Process

Model of Effectiveness of State Level Collaboration

Initial focused on Child Welfare Program Improvement Plan

Hoped to lead to development of legislation for a comprehensive cross system plan for behavioral health services for children and families

Original delegates and systems:

Jane Bisbee, DFC
Brenda Hamilton, FOF
Ron Leffler, DOC
Nancy Zemaitis, DOE/DEL
Kate Rusher, JJ
Terri Falker & Ryan Pastorious, SBA
Cheryl Shearer, DMHA
Betty Walton, DMHA & IUSSW

Has meet at least monthly since summer 2004

Quarterly Stakeholder Meetings – May 8, 10 to noon, CC22

MH of Children in Child Welfare

- **Children in the child welfare system are at higher risk for mental health and addiction issues.**

- **More than 80% of children in foster care have developmental, emotional, or behavioral problems.**

- **Mental health services are repeatedly identified as their number one health care need.**

- **According to the U.S. Department of Health and Human Services, 75%-80% of the children who need mental health services do not receive them (CWLA, 2004).**

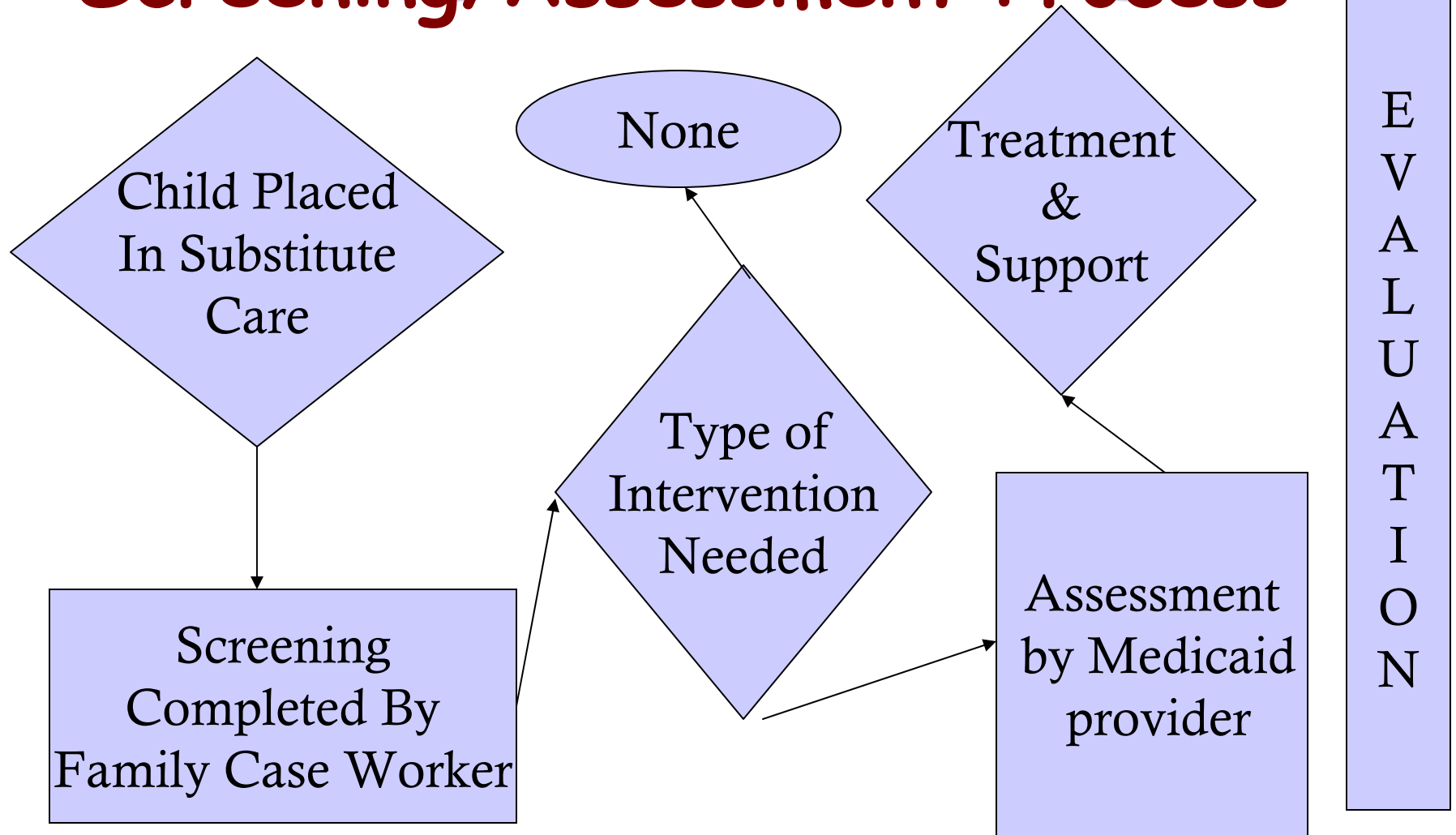# Collaborative Development, Implementation, & Monitoring Processes

Description of the Initiative

- **Model Initiative to Demonstrate Effectiveness of Cross System Collaboration**
- **Child and Family Services Review – Program Improvement Plan (PIP)**
- **Indiana's Early Identification and Intervention Initiative (President's New Freedom Commission on Mental Health, 2003)**
- **Foundation for Transformation of Indiana's Behavioral Health System for Children and Families**

Child Welfare Screening/Assessment Process

Child Placed In Substitute Care

None

Treatment & Support

E V A L U A T I O N

Screening Completed By Family Case Worker

Type of Intervention Needed

Assessment by Medicaid provider

Difference in Screening & Assessment

SCREENING

"Most definitions of screening for mental health and substance use problems (describe a relatively brief process designed to identify youth that are at increased risk of having disorders that warrant immediate attention, intervention, or more comprehensive review" (Grisso & Underwood, p. 6, 2004).

ASSESSMENT

- More comprehensive, individualized examination
- More lengthy and labor intensive process (i.e., multiple interviews, record reviews, collateral contacts, and, sometimes, psychological testing)
- Usually administered by trained mental health professional
- Purposes: to evaluate the type and extent of mental health or addiction disorders and make treatment recommendations, level of care determination, outcome measure
- Who: subset of youth identified through the screening process as requiring follow-up

Child Welfare Screening INSTRUMENTS

**SCREENING TOOL
TO BE USED BY DCS STAFF now on ICWIS:**

○ **Mental Health Screening Tool (MHST)**
  - **5 years to adult**

○ **Mental Health Screening Tool (MHST)**
  - **0-5**

(http://www.cimh.org)
(On website, look for Foster Care)

Quality Assurance/Evaluation

- **Review sample of children during local child welfare quality assurance reviews regarding timely screening for mental health and addiction issues & referral for assessment and treatment**

- **Data is reported monthly to local county offices regarding number of children eligible for screening and the number who were screened**

Families as Partners

"Nothing About Us Without Us"

Partners at every level and step of the way…policy development, program planning, direct services, training providers, support for other families, evaluation….

Indiana's CST Endorsed Shared Values & Principles

(Stroul & Friedman, 1986)

Across All Systems Serving Children & Families

- **Child Centered**
- **Family Focused**
- **Strength Based**
- **Least Restrictive**
- **Monitor Outcomes**
- **Early Identification & Intervention**
- **Coordinated**
- **Individualized Based on Needs**
- **Open Access**
- **Health and Safety**

CHILD WELFARE MENTAL HEALTH SCREENING INITIATIVE

Evaluation Progress Report

Eric R. Wright

Anthony H. Lawson

Center for Urban Policy and the Environment

EVALUATION OVERVIEW :

- Pre-Post Comparison of Mental Health Referrals and Treatment

- De-identified Data (MOU for Data Sharing)
  - Division of Mental Health and Addiction
  - Department of Child Services
  - Office of Medicaid Policy and Planning

EVALUATION OVERVIEW : RESEARCH PERIODS

- Benchmark Period/Pre-screening Period
  - July 1, 2003 through June 30, 2004

- Pilot Period
  - July 1, 2004 through December 31, 2004

- Full Implementation Period
  - January 1, 2005 through March 31, 2005

CLIENT FLOW

	Number of DCS Referrals	Number (%) of Children with a Previous CHINS	Number (%) of Children with a Previous Removal
Benchmark Period	1742	296 (17.0%)	243 (13.9%)
Pilot Period	1292	239 (18.5%)	172 (13.3%)
Full Implementation Period	829	179 (21.6%)	161 (19.4%)

CLIENT FLOW ANALYSIS

	Total Number of CHINS/Removals	Number (%) of Children Screened for Mental Health/Addiction Needs	Number (%) of Children with an Identified Risk	Number (%) of Children receiving assessment	Number (%) of Children receiving Mental Health/Addiction treatment [1]
Benchmark Period (July 1, 2003-June 30, 2004)	1742	N/A	N/A	215 (12.3%)	395 (22.7%)
Pilot Period (July 1, 2004-December 31, 2004)	1292	436 (33.7%)	167 (38.3%)	106 (8.2%)	248 (19.2%)
Full Implementation Period (January 1, 2005-March 31, 2005)	829	622 (75.0%)	249 (40.0%)	111 (13.4%)	190 [2] (22.9%)

[1] Only includes children who received services within 90 days of their current CHINS or removal and had never received services prior as indicated in data provided by DMHA and OMPP.

[2] Children included in the full implementation period may not have had an opportunity to receive services within the 90 day time frame. As a result, there is a bias for children whose DCS contact occurred early in the quarter.

MENTAL HEALTH TREATMENT

	Number (%) of children receiving MH services within 3 months of contact [1]	Number (%) of children receiving services within 6 months of contact [1]	Number (%) of children receiving services within 12 or more months of contact [1]	Average Cost of Services per DCS Child per Quarter Compared to all Children
Benchmark Period	655 (37.6%)	812 (46.9%)	1027 (59.0%)	$1008 ($551)
Pilot Period	390 (30.2%)	463 (35.8%)		$1725 ($1039)
Full Implementation Period	358 (43.2%)			$995 ($873)

[1] **Numbers and percentages include children who had received services prior to their current CHINS or removal.**

[2] **Based upon cost data provided by OMPP**

RECIDIVISM

	Benchmark	Pilot	Full Implementation
Age	↑	↑	↑
Race	NS	↓	NS
Female	NS	NS	NS
Receiving OMPP Services	↓	NS	↓
Receiving DMHA Services	NS	↓	NS
Risk Identified		NS	↑

PLACEMENT STABILITY

	Benchmark	Pilot	Full Implementation
Age	↓	↓	↓
Race	NS	NS	NS
Female	NS	NS	NS
Receiving OMPP Services	↑	↑	↑
Receiving DMHA Services	NS	↑	NS
Risk Identified		↑	NS

Stakeholders' Meetings
(hosted by Cross System Team)
DCS Screening Results
July – September 2005

	# of Children	%
Not Screened	547	23
Rescreen*	643	27
No Identified MH Risk	673	28
MH Risk - Refer	107	4
MH Risk- Urgent	418	18
Total	2388	
*Insufficient	information	

DCS Screening Results October - December 2005
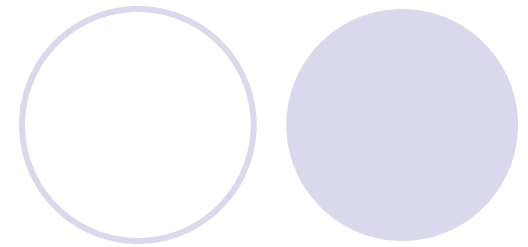
	# of Children	%
Not Screened	349	16.9
Rescreen*	557	27
No Identified MH Risk	693	33.7
MH Risk - Refer	95	4.6
MH Risk- Urgent	362	17.6
Total	2056	
*Insufficient	information	

DCS Screening Results - 2005
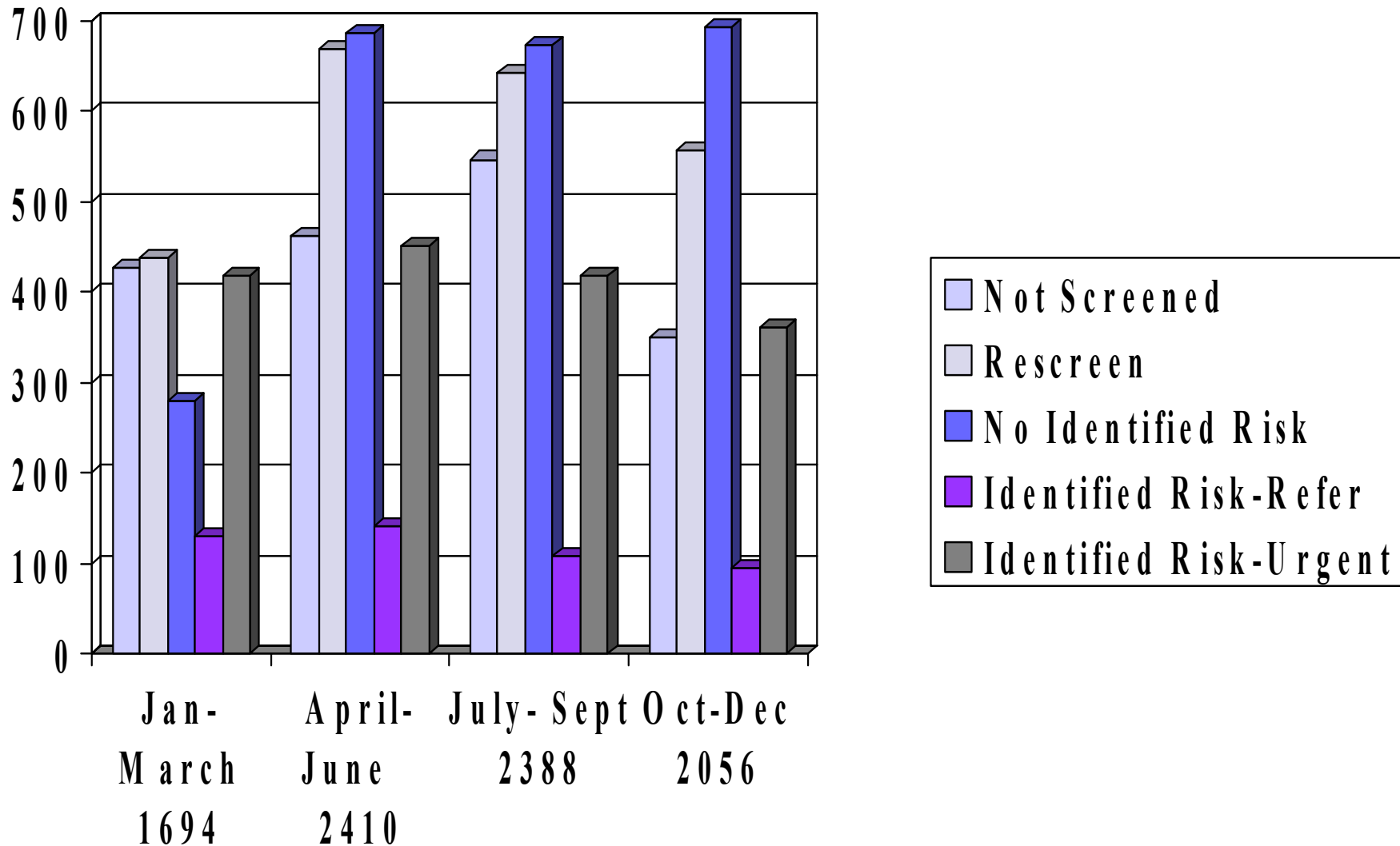
CONCLUSIONS

- Early indications suggest that the screening initiative is getting more children into behavioral health treatment sooner.

- The costs of providing these services is about the same in the pre- and post - implementation periods.

How Does the Initiative Relate to Transformation?

- **Information used to improve practice:**
  - ** Share Data with Stakeholders & Providers
  - ** Early Childhood Mental Health
  - ** Evidence Based Assessment and Outcome Management
  - ** Persistently modeling cross-system collaboration

Project Coordinator

- **Monitors Current Data (targets outliers)**
- **Day-to-day coordination between state level child welfare and mental health agencies**
- **Contact with DCS Regional & County Directors**
- **Local on-site training/coaching/mentoring of case managers/ supervisor**
- **Next Focus: Ensuring children with identified needs are routinely referred for assessment and are receiving needed services and support**

Use data to improve practice

Example: Early Childhood Mental Health

Workforce Development Issues:
* DCS
*Mental Health Providers
*Foster Parents

- **Response:** Training and Consultation by IN's Infant and Toddler MHA for providers, child welfare staff (curriculum development), and foster parents

- **Funding:** Indiana Juvenile Justice Institute using federal juvenile justice funds

Assessment Committee

- **Chose 30 individuals from pool of 50+**
- **Assured representation across systems, families, youth, providers, and academic community**
- **Meet October 2004 –July 2005**
- **Reviewed many standard assessment tools and related decision support/quality management processes**
- **Technical Assistance funded by NASMHPD**
- **Recognition by committee that final recommendation should fit the transformation of Indiana's child service systems**
- **Reviewed possibilities and finalized recommendation**

Recommendation

Child and Adolescent Needs and Strengths (CANS): Comprehensive Version (Lyons, 2004)

Came closest to meeting criteria of:
- **Useful to child and family**
- **Inform care plan**
- **Decision Support**
- **Outcomes**
- **Communication**
- **Risk Adjusted Funding**

Recommend using CANS across IN's child service systems ...mental health & substance use, child welfare, juvenile justice, early childhood, & Medicaid (education)

History: Screening & Assessment in IN

DMHA

Hoosier Assurance Plan (1994)

- **CAFAS**

- **Hoosier Assurance Plan Instrument for Children (HAPI-C)**

Across Systems

- **Policy Academy (2002)**
- **CWMH Screening, Assessment & Treatment (2004) (Mental Health Screening Tool)**
- **Bar Association Conferences (2003-4)**
- **Juvenile Law Commission (2004)**
- **Assessment Committee (2004-2005)**

Description: CANS

- **Assesses children and their families prospectively and retrospectively regarding the needs and strengths of the child.**

- **Structured assessment**

- **Quantifies good psychosocial assessment**

- **Dimensions relevant to service planning and decision making**

- **Multiple versions (MH, CW, JJ, DD, 0-4, comprehensive)**

CANS measures:
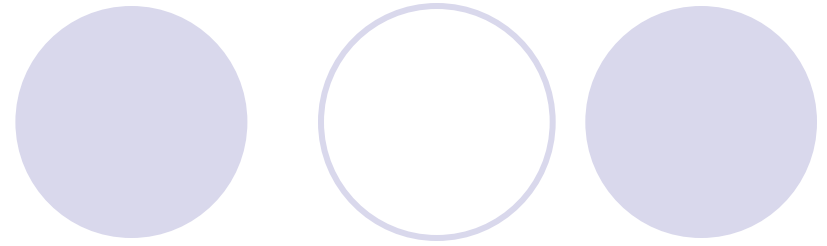
- **Mental health/co-existing conditions (problem)**
- **Functioning**
- **Risk behaviors**
- **Family/caregiver capacity**
- **Child safety**
- **Substance use**
- **Crime/delinquency**
- **Problems (0-4)**
- **Risk factors (0-4)**
- **Care intensity**
- **Strengths**
- **Trauma (emerging scale)**

(Core Items with subscales opening depending upon child's situation.)

4 Point Measurement Scale

0 No evidence of problem

1 Mild degree of dimension

2 Moderate evidence of problem

3 Severe or profound degree

0 No need for action

1   Need for preventive services or watchful waiting to see if action warranted in future

2 Need for Action

3 Need for immediate or intensive action

Strength Based Scale

0   Strength, which is positive

1   Strength exists, but not the focus

2   Strength is identified, but needs to be build
        upon

3   No strength has been identified
      (system must identify this and build upon it)

Useful to child and family

- **Engagement**
- **Family Voice**
- **Family Structured Interview (draft)**
- **Understandable**
- **Monitors progress**

Treatment/Care Planning

- **Areas of need with scores of 2 or 3 will appear in service plan**

- **Areas of strength are used to address areas of need in plan**

- **If no identified strengths, develop strengths**

Decision Support

- **Algorithms can be established to determine benchmarks for levels of care in the continuum of behavioral health care for children and adolescents—**

  state hospital and waiver, psychiatric residential treatment facilities, treatment foster care, intensive community based services (systems of care), supportive case management, outpatient services

Outcome Measure

- **Repeated measures using CANS provides measure of change in multiple life domains.**

- **Possible time periods: 3 months, 6 months**

- **Requires development of database in which to collect data and analyze data**

- **Real time use of data would provide quality improvement functioning and possible utilization management**

Communication

- **CANS developed from Communication Theory**

- **Minimal jargon**

- **Facilitates communication across systems**

CANS already in Indiana

- **Pilot implementation of CANS in Lake County (DCS and JJ)**

- **Pilot implementation in Lawrenceburg area to determine eligibility and level of intensive community based services**

- **Circle Around Families (Lake) & DAWN considering implementation**

Development of IN's CANS, Comprehensive Multisystem Assessment: Current Status

- **Interagency Work Group**
- **Tailor Short and Long Version**
- **Implementation Plan**
- **Training/Certification**
- **Data Collection**
- **Establish Algorithms for Decision Support**
- **Develop Outcome Quality Management Process**

Work Group…
- **Child Welfare**
- **Education**
- **Judicial Center (judges & probation)**
- **Corrections**
- **Medicaid**
- **Mental Health**
- **Addictions**
- **First Steps**

Consultation from John Lyons, PhD, Northwestern University

To learn more about the CANS:

- **Check out the Buddin Praed Foundation website at http://www.buddinpraed.org/**

- **Attend the 3rd Annual CANS Conference, Chicago, May 22-24, 2006**

- **Attend Child & Adolescent Conference, August 3 & 4 in Fort Wayne**

PARTNERS

- ❖ **Governor's Office**
- ❖ **IN Federation of Families, Other Family Members**
- ❖ **State Budget Agency**
- ❖ **Family and Social Service Administration**
   Division of Mental Health and Addiction
   Office of Medicaid Policy and Planning
- ❖ **Department of Child Services**
- ❖ **Department of Education, Division of Exceptional Learners**
- ❖ **Department of Correction**
- ❖ **Juvenile Judges Quality Improvement Committee**
- ❖ **Indiana Center for Mental Health Policy**
- ❖ **Indiana Consortium for Mental Health Services Research**
- ❖ **Indiana University School of Social Work**
- ❖ **Indiana Criminal Justice Institute (Grant)**
- ❖ **State Department of Health**
- ❖ **First Steps, IDEA, Part C**

Discussion
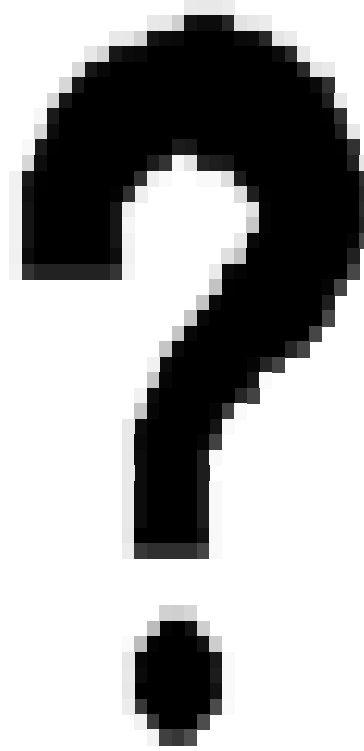
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